The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-877-324-3136 or visit the Live*Total Health* page on the Garden (or livetotalhealth.com) and click on the Quantum Health button. For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary on the Quantum Health portal or call 1-877-324-3136 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$750	$1,500	
	Per family:	$1,500	$3,000	
Are there services covered before you meet your deductible?	**Yes.** Network preventive care services, prescription drugs, office visits, and other services which apply a co-payment.			This plan covers some items and services even if you haven't yet met the deductible amount. But a co-payment or co-insurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Per participant:	$3,500	$7,000	
	Per family:	$7,000	$14,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes:** See www.anthem.com or call 1-877-324-3136 for a list of network providers.			This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network

		provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

 All **co-payment** and **co-insurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-payment, deductible waived	30% co-insurance after deductible	Co-payment is applied per visit.
	Specialist visit	$60 co-payment, deductible waived	30% co-insurance after deductible	Co-payment is applied per visit.
	Preventive care/screening/ immunization	No charge, deductible waived	30% co-insurance after deductible	**Calendar Year Maximum:** one (1) adult visit. This limit does not apply to the well-woman visit. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% co-insurance after deductible	30% co-insurance after deductible	——————————none——————————
	Imaging (CT/PET scans, MRIs)	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required for MRI/MRA and PET scans.**

* For more information about limitations and exceptions, see the plan or policy document at www.benefitsatscotts.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail Pharmacy:** $10 co-payment **Retail-90/Mail Order:** $25 co-payment	Not covered	Retail: Up to thirty (30) day supply; up to eighty-four (84) day supply for maintenance drugs. Mail Order: Eighty-four (84) to ninety (90) day supply. Prescription drugs are not subject to the deductible. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.caremark.com.
	Preferred brand drugs	**Retail:** 25% co-insurance: $20 minimum $100 maximum **Retail-90/Mail Order:** 25% co-insurance: $50 minimum $250 maximum		
	Non-preferred brand drugs	**Retail:** 40% co-insurance: $40 minimum $150 maximum **Retail-90/Mail Order:** 40% co-insurance: $100 minimum $375 maximum		
	Specialty drugs	Benefits will be based on drug classification listed above	Not covered	Specialty drugs are limited to thirty (30) day supply and are dispensed exclusively through Caremark specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.**
	Physician/surgeon fees	10% co-insurance after deductible	30% co-insurance after deductible	——————————none——————————
If you need immediate medical attention	Emergency room care	$150 co-payment plus 10% after network deductible		The emergency room co-payment is waived if admitted.
	Emergency medical transportation	10% co-insurance after network deductible		——————————none——————————
	Urgent care	$75 co-payment, deducible waived	30% co-insurance after deductible	——————————none——————————

* For more information about limitations and exceptions, see the plan or policy document at www.benefitsatscotts.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.**
	Physician/surgeon fees	10% co-insurance after deductible	30% co-insurance after deductible	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 co-payment, deducible waived	30% co-insurance after deductible	**Pre-certification is required for partial hospitalization and intensive outpatient treatment.**
	Inpatient services	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.**
If you are pregnant	Office visits	**Initial office visit:** $30 co-payment, deductible waived **Subsequent office visits:** 10% co-insurance after deductible	30% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% co-insurance after deductible	30% co-insurance after deductible	
	Childbirth/delivery facility services	10% co-insurance after deductible	30% co-insurance after deductible	
If you need help recovering or have other special needs	Home health care	10% co-insurance after deductible	30% co-insurance after deductible	**Calendar Year Maximum:** One hundred twenty (120) days per plan participant. Includes private-duty nursing services. **Pre-certification is required.**
	Rehabilitation services	$30 co-payment, deductible waived	30% co-insurance after deductible	**Calendar Year Maximum:** sixty (60) visits for occupational and physical therapy combined; twenty-five (25) visits for speech therapy.
	Habilitation services	$30 co-payment, deductible waived	30% co-insurance after deductible	——————none——————
	Skilled nursing care	10% co-insurance after deductible	30% co-insurance after deductible	**Calendar Year Maximum:** one hundred (100) days per plan participant. **Pre-certification is required.**
	Durable medical equipment	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required for DME rentals and purchases over $1,500.**

* For more information about limitations and exceptions, see the plan or policy document at www.benefitsatscotts.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Hospice services	10% co-insurance after deductible	30% co-insurance after deductible	**Pre-certification is required.**
If your child needs dental or eye care	Children's eye exam	No charge	40% co-insurance after deductible	**Calendar Year Maximum:** one (1) per plan participant.
	Children's glasses	Not covered	Not covered	——————————none——————————
	Children's dental check-up	Not covered	Not covered	——————————none——————————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture (except when used in lieu of anesthetic)
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (pre-certification required)
- Chiropractic care [Calendar Year Maximum: twenty (20) visits]
- Hearing aids (Lifetime maximum: $5,000)
- Infertility treatment (Lifetime maximum: $20,000 for medical, $10,000 for prescription drugs)
- Routine eye care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator at Scotts Benefit Service Center, P.O. Box 5295, Cherry Hill, NJ 08034-5295. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
You may also contact the Plan Administrator for appeals information. The Plan Administrator's name, address, and telephone number are:

The Scotts Company LLC
14111 Scottslawn Road
Marysville, OH 43041
1-877-324-3136

Does this plan provide Minimum Essential Coverage? **Yes**

* For more information about limitations and exceptions, see the plan or policy document at www.benefitsatscotts.com.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-324-3136.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-324-3136.
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-877-324-3136.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-324-3136.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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* For more information about limitations and exceptions, see the plan or policy document at www.benefitsatscotts.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payments and co-insurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$750**
Specialist co-payment	**$60**
Hospital (facility) cost sharing	**10%**
Other cost sharing	**10%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Co-payments	$60
Co-insurance	$2,300
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,130**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$750**
Specialist co-payment	**$60**
Hospital (facility) cost sharing	**10%**
Other cost sharing	**10%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Co-payments	$700
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$750**
Specialist co-payment	**$60**
Hospital (facility) cost sharing	**10%**
Other cost sharing	**10%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Co-payments	$300
Co-insurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.